Patient Request for Financial Assistance Form

Phone: 1-844-443-6879 **Fax: 1-844-329-2447** **www.GentryHealthServices.com / email: info@GentryHealthServices.com**

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ______________________________	**Prescriber Name:** ______________________________
DOB: _____/_____/_______ **Gender:** ____________________	**NPI:** ____________________ **DEA:** ____________________
Address: ______________________________	**City, State, Zip:** ______________________________
City, State, Zip: ______________________________	**Phone:** ____________________ **Fax:** ________________
Phone: ________________ **Alternate:** ________________	**Contact Person:** ______________________________
E-Mail: ______________________________	

INFORMATION REQUIRED FOR FINANCIAL ASSISTANCE APPLICATION

Social Security Number: ____________________ **Monthly Income:** ____________ **Number living in Household:** ______________

THERAPY TYPE / DISEASE STATE INFORMATION

What is the patient's medical condition or diagnosis? ______________________________

What medication has the patient been prescribed? ______________________________

HEALTH INSURANCE	PRESCRIPTION INSURANCE
NOTE: Information requested below can be found on the front and back of your health insurance and prescription insurance cards.	
Health Insurance Name: ______________________________	**Rx Insurance Name:** ______________________________
ID #: ______________________________	**Rx ID#:** ________________ **Rx Grp:** ________________
Group #: ______________________________	**Rx Bin#:** ________________ **Rx PCN:** ________________
Phone #: ______________________________	**Phone #:** ______________________________

AUTHORIZATION TO USE ABOVE INFORMATION TO PURSUE FINANCIAL ASSISTANCE

Requester Signature: ______________________________ **Date:**______/______/______

Please Print Name: ______________________________

If requester is NOT the patient

Requester's Name: ______________________________

Address: ______________________________ **City, State, Zip:** ______________________________

Phone #: ______________________________ **Alternate #:** ______________________________

E-Mail: ______________________________ **Relationship to Patient:**______________________________

CONFIDENTIALITY NOTICE: THE INFORMATION IN THIS TRANSMITTAL IS CONFIDENTIAL AND INTENDED ONLY FOR THE RECIPIENT LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR A PERSON RESPONSIBLE FOR DELIVERING THIS TRANSMITTAL TO THE INTENDED RECIPIENT YOU ARE HEREBY NOTIFIED THAT ANY DISTRUBTION OR COPYING OF THIS TRANSMITTAL IS PROHIBITED. IF YOU RECEIVE THIS TRANSMITTAL IN ERROR, PLEASE IMMEDIATELY NOTIFY GENTRY HEALTH SERVICES AT 1-844-483-6789 AND RETURN THE TRANSMITTAL TO US AT OUR EXPENSE.